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	IL6006472	A. BUILDING: _____ B. WING _____	08/27/2015

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Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.700a) 350.700b) 350.700c) 350.1210 350.1230d)1) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by:	Z9999		

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Based on interview and record review the facility failed to ensure the safety of 1 (R1) individual who is assessed as needing a wander guard bracelet and who has a history of elopement, as evidenced by the facilities failure to:

* thoroughly investigate an incident on 7/19/15 when R1 left the facility and walked towards the local gas station without staff supervision.
* implement changes after the investigation of the incident on 7/19/15 to ensure R1 did not leave the facility without staff knowledge.
* obtain guardianship for R1 after the physician assessed R1 in January of 2015 as being "totally incapable of making informed decisions"
* notify Public Health of the incident on 7/19/15.
* train/re-train staff related to R1's ability to smoke outside without staff supervision.

Findings Include:

Review of the facility Admission sheet (not dated) documents R1 is a 66 year old male who functions at a Mild Level of Intellectual Disability. R1's diagnoses include; dementia, diabetes, and ethanol dependence. The admission sheet continues to document R1 is legally competent and does not have a guardian.

Review of the Initial Social History Assessment documents under summarization of pertinent social information; "Records indicate R1 allegedly assaulted a member of his extended family who was a minor at the time. He (R1) was tried in (name of County) with aggravated criminal sexual assault, three counts of criminal sexual assault, and two counts of aggravated criminal assault. He (R1) was found unfit to stand trial on these

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charges on 10/24/1991. R1 had a subsequent forensic admission to (name of facility) on 4/14/2004 after he was found unfit to stand trial by the (name of court) on a charge of aggravated arson....Approximately one year later, R1 was charged with Class I felony residential arson and criminal damage to property and found unfit to stand trial...On 12/30/2010, R1 was admitted to a DD CILA home. On 5/26/13, R1 was admitted to (name of local hospital) when he was found to be unresponsive. On 6/3/13, R1 was admitted to (name of nursing home). On 8/4/14, R1 was admitted to (name of current facility)."

Review of R1's Individualized Habilitation Plan dated 7/27/15 documents under recommendations that R1's IQ is 34 and overall functioning level is 3 years 5 months.

Under Legal Competency status R1's Admission sheet documents, "Competent."

Review of R1's Psychological report, dated 8/25/14, documents under Recommendations; "R1 was admitted to this home on 8/4/14. He is legally competent. R1 has a history of serious antisocial behavior including alcoholism, arson, and criminal sexual abuse...test results prior to admission reported a full scale IQ of 56. He completed 9 years of formal education and has excellent communication skills."

Review of the "Request for Consultation" dated 1/20/15 documents, "He (R1) has cognitive impairment. He now has a dx (diagnosis) of dementia. His judgment is def (definitely) poor. He needs to be further eval (evaluated) for dementia meds over the next few wks (weeks)."

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R1's record contained court documents (petition for guardianship) that contained R1's physician assessment dated 01/08/15 and documented, Under section 1. "R1 has developmental disability and dementia. He is unable to make informed decisions in his own best interest." Under section 3. R1's physician stated, "Pt (patient-R1) is totally incapable of making informed decisions about personal or financial issues."

Review of the facility "Request for Consultation" dated 1/20/15 R1's psychiatrist documents, "He (R1) has cognitive impairment. He now has a dx (diagnosis) of dementia. His judgement is def (definitely) poor. He needs to be further evaluated for dementia meds. (medications) over the next few weeks."

During interview on 8/18/15 at 3:30 PM, E2 (Assistant Administrator/QIDP) stated R1 was his own guardian. When asked about the court documents in his chart with the physicians assessment, E2 stated, "It got dropped in January because he (R1) said he didn't want a guardian."

During interview on 8/18/15 at 3:30 PM, E1 (Administrator) stated, "I have talked with R1 and he has agreed to have a guardian now. The attorney will be meeting with him the end of this month."

Review of the facility Behavior Management meeting dated 1/12/15 documents, "1. R1 walked away from the facility 12/29/14 without his walker and the police picked him up and brought him back to the facility. The resident did not tell anyone at the facility where he was going. 2. Resident is a bad diabetic. In the past consuming 2 to 3 pints of whiskey per day, a history of felony

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charges at mental health facility, the court approved a conditional release plan to have supervised off-ground privileges and reside in a supervised residential program and they also found him unfit to stand trial. A detailed history of why he shouldn't be in the community alone can be found in his chart. 3. After reviewing the information found in his chart, inclusive of his history, and his walking away from the facility, the team feels that we acted in his best interest. We were definitely considering his health. The needs of R1 will be reviewed quarterly and at the end of 12 months the team will review the need to keep or remove the wander guard per his elopement program."

Review of the facility incident/accident report, dated 7/19/15 documents at 1:00 PM, it was discovered that R1 was not in the facility. At 1:15 PM, the incident/accident report documents a full assessment completed on R1 by the nurse with no injuries noted. The incident/accident report states, "walked to (name of local gas station) for chips." The Injury/Accident report documents Public Health was not notified.

Review of the facility policy "Missing Person/Elopement" dated 9/25/07 documents under "9. The Resident Services Director will notify Department of Public Health with (sic) 24 hours of elopement. (9/29/05)"

During interview on 8/18/15 at 3:30 PM, E2 (Assistant Administrator/Qualified Intellectual Disability Professional-QIDP) stated, "No, we didn't report it to Public Health because we didn't feel like it was an elopement since he was going to get chips and come back."

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Review of E3 (Direct Support Person-DSP) statement related to the incident and dated 7/19/15 documents, "R1 went out to smoke at 1 PM on porch staff noticed he wasn't sitting on porch, staff immediately checked room and grounds, staff then proceeded to check cemetery and road. Nurse received call that he was over by the police station. Staff took van and picked him up. This staff (E3) asked R1 where he was going he said he was going to (name of local gas station) (by the police station) to get a bag of chips."

During observation on 8/18/15 this surveyor drove to the area were R1 was picked up by staff. R1 had walked approximately 1/10th of a mile on a busy road and crossed an active railroad tracks. R1 was getting ready to cross a road that is heavily traveled by local traffic as well as semi tractor trailers.

During interview on 8/18/15 at 5:07 PM, E3 (DSP) stated, "I noticed when we were getting ready to do the 1:30 PM check, probably a few minutes early that he wasn't on the grounds. We did a grounds check including the facility, then I went off grounds and found him right before (name of local gas station) and he said he was going to buy a bag of chips." When asked why the wander guard bracelet didn't alarm, E3 stated, "I can't say exactly it was a month ago." When asked if a staff member stayed outside with R1 while he was smoking, E3 stated, "Not all the time." When asked if there was a specific staff member assigned to monitor R1 when he was outside, E3 stated, "No."

Review of the facility Wander guard flow sheet documents R1 was accounted for at 1:00 PM.

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The 1:30 PM check is blank. There is a note documented on the back of the flow sheet that states, "7/19/15 at 1:25 PM was doing wander guard check noticed client (R1) had walked off." This note is signed by E4 (DSP).

During interview on 8/18/15 at 5:16 PM, E4 (DSP) stated he was on his way to get R1 for a shower when he realized R1 wasn't in the building. E4 stated he went outside to look for R1 then reported to the nurse that R1 was not on the grounds and then E4 and several other staff got in cars to look for R1. When asked if there was a staff member assigned to monitor R1 when he went outside to smoke, E4 stated, "No."

Review of the incident summary documented by E2 (Assistant Administrator/QIDP) documents on 7/20/15, "On 7/19/15 R1 went out on front porch to smoke. Staff were aware that he was on porch at 1 PM. E3 (DSP) was in the dining room. She looked out on porch and realized that R1 was not there. Staff began looking for him. He was located by the police station and stated he was going to (name of local gas station) for chips. Administrator (E1) spoke with R1 regarding incident. She explained to him that she was concerned for his safety and that if he wanted to go get chips he should tell staff so they could take him. He told her he would tell staff the next time. R1 is his own guardian. R1 will attend...class where he will discuss walking in the community and safety issues."

During interview on 8/24/15 at 1:15 PM, E5 (Licensed Practical Nurse-LPN) stated she had received a phone call from a lady in the community (she did not get her name) who described an individual walking by the cemetery. Her description matched the description of R1.

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The facility staff had already began looking for him and after the phone call. E5 sent staff to pick R1 up.

Review of R1's walking in the community assessment, dated 8/20/14, R1 was able to 1) look both ways before crossing the street. 2) walk on the sidewalk 3) walk on shoulder of road if no sidewalk 4) stop at stop signs 5) discriminate correctly between red and green lights. R1 was not able to 1) cross street at facility, 2) cross street with stop sign independently 3) find his way home from 2 blocks away, 4) find his way to and back from one place in the neighborhood, 5) find his way to and back from at least 5 different places in the neighborhood, 6) complete all of the steps in the walking program.

R1 was re-evaluated on 10/22/14 for the walking in the community assessment. R1 was able to find his way home from 2 blocks away, cross the street with a stop sign independently, and to find his way to and back from one place in the neighborhood. This assessment does not address being able to safely cross the railroad tracks.

During interview on 8/24/15 at 10:25 AM, R1 stated he was doing well and the staff treated him well. When asked about walking to the gas station R1 replied, "Yeah, they don't want me to do that."

During interview on 8/18/15 at 3:39 PM, when asked if the facility had reported the incident on 7/19/15 to IDPH. E2 (Assistant Administrator/QIDP) stated, "No, we didn't feel like it was an elopement since he was going to get chips and come back." When asked about the time discrepancy (incident/accident report

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documents R1 back in the building at 1:15 PM, Wander guard flow sheet documents R1 noted missing at 1:25 PM) related to the incident E2 stated, I didn't see the time discrepancy until after the investigation." When asked who was supposed to be monitoring R1 while he was outside, E2 stated, "E3 (DSP) was in the dining room and realized he was gone but I don't know who else." E2 continued to state that someone made a phone call that he (R1) was over by the police station." When asked who called, E2 stated, "I don't know its in the nurses notes." When told that there was no documentation related to the incident in the nurses notes, E2 stated, "Well they took the call." E2 continued to state, "We allow him to go out on the porch and smoke that's how he got past the wander guard bracelet." E2 stated, when asked if the facility had trained/re-trained staff after the incident on 7/19/15, they had not and R1 was still allowed to sit outside without staff being with him while he smoked.

E2 (Assistant Administrator) stated on 8/24/15 at 9:00 AM that she had not interviewed E4 or E5 (nurse on duty on 7/19/15) as part of the investigation.

When asked on 8/18/15 at 4:30 PM if there was any follow up completed after the incident of 7/19/15 or if staff were trained or re-trained, E2 stated, "No."

E2 continued to state on 8/18/15 at 3:39 PM, that the facility had not continued with obtaining a guardian for R1 in January of 2015 because R1 did not want a guardian at that time.

R1 has a history of elopement in December of

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Z9999	Continued From page 10 2014. He was assessed by his physician as being totally incapable of making informed decisions about personal or financial issues. The team met and determined to ensure R1's safety a wander guard bracelet would be implemented. R1 smokes and the facility allowed R1 to sit on the porch without staff supervision after assessing him and finding the need for a wander guard bracelet to ensure R1 did not leave the facility again without staff being aware. On 7/19/15, R1 walked away from the facility while sitting outside smoking without staff supervision. R1 walked approximately 1/10th of a mile and crossed an active railroad track. After this incident the facility failed to: do a thorough investigation, implement changes to ensure R1 was monitored by staff when outside of the facility, train/re-train staff, notify public health R1 had eloped. These failures put R1's safety and well being at risk. (B)	Z9999		